HIGHMARK

Western New York

Community Blue Medicare HMO

Summary of Benefits

January 1, 2026 to December 31, 2026

To enroll in the following plan(s), you need to be entitled to Medicare Part A, enrolled in Medicare Part B, and live in one of these counties:

Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming

This summary of benefits doesn't list every service, limitation, or special circumstance.

Visit us at **medicare.highmark.com** to get more benefit information including:

- **Evidence of Coverage** *(full list of benefits)*
- **Provider and Pharmacy Directories**
- **Formulary** *(full Part D prescription drug list)*

If you need printed copies, call us at **1-800-329-2792** (TTY 711). We're available 7 days a week, 8 a.m. to 8 p.m.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **medicare.gov** or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY 1-877-486-2048.

Community Blue Medicare HMO has a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, the plan may not pay for these services.

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	Community Blue Medicare HMO Merit (HMO)
Premium	$0
Part B Premium Reduction	$81
Deductible	$250
Max Out-Of-Pocket	$8,300
Inpatient Hospital Stay*	Days 1 - 7: $345 copay per day per admit & Days 8 - 90: $0 copay per admit
Outpatient Hospital Coverage*	ASC[1]: $425 copay Facility: $475 copay
Doctor Office Visit	PCP: $0 copay Specialist: $50 copay
Preventive/Screening	Covered in Full (Office visit copays may apply)
Emergency Room	$115 copay
Urgently Needed Services	$40 copay
Lab* & Diagnostic Tests*	Freestanding Lab-Diagnostic Tests: $10 copay Office/Outpatient-Diagnostic Tests: $20 copay
X-Rays*/ Advanced Imaging*	X-ray: $50 copay Advanced Imaging: $300 copay
Hearing Services	Medicare Covered: $50 copay. Routine: $45 copay (1 Per Year). TruHearing Advanced: $699 copay (2 Aids Every Year); TruHearing Premium: $999 copay (2 Aids Every Year)
Dental Services	Medicare Covered: $50 copay. Routine Office Visit: $0 copay per service (2 per year). Routine X-rays: $0 copay (1 per year). Comprehensive 50% coinsurance with a maximum $1,500 allowance (preventive and comprehensive combined) (per year). See the EOC for full benefits.
Vision Services	Medicare Covered: $50 copay. $0 diabetic retinal eye exam. Routine: $0 copay (1 per year). $0 copay for eyeglasses or contact lenses after cataract surgery. $100 annual eyewear allowance.
Mental Health Services	Inpatient: Days 1 - 7: $295 copay per day per admit & Days 8 - 90: $0 copay per admit*; $2,065 OOP Max per year; Outpatient: $40 copay
Skilled Nursing Facility*	$0 copay/day (days 1 - 20), $218 copay/day (days 21 - 100)
Physical Therapy	$35 copay
Ambulance (per one-way trip)*	$450 copay
Transportation	Not Covered
Medicare Part B Drugs*†	20% coinsurance
OTC	Not Covered
Durable Medical Equipment*	20% coinsurance $0 copay for compression stockings, diabetic shoes/inserts
Formulary	Performance

*Indicates a service that requires prior authorization.

ASC[1]=Ambulatory Surgery Center

†Certain rebatable drugs may be subject to a lower coinsurance. Insulin cost sharing is subject to a coinsurance cap of $35 for a one-month's supply of insulin.

Community Blue Medicare HMO Merit (HMO)

DRUG

After you pay your yearly deductible (excludes insulins), you pay the following until your total yearly drug costs reach $2,100. Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Deductible	Tier 1-Tier 2: $0, Tier 3-5: $615			
Initial Coverage	**Preferred Retail Cost-Sharing**	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
		Tier 2 (Generic)	$3 Copay	$9 Copay
		Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	20% of the cost	20% of the cost
		Tier 4 (Insulin)	$35 Copay	$105 Copay
		Tier 4 (Non-Preferred Drug)	25% of the cost	25% of the cost
		Tier 5 (Specialty Tier)	25% of the cost	Not Applicable
	Standard Retail Cost-Sharing	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	$7 Copay	$21 Copay
		Tier 2 (Generic)	$17 Copay	$51 Copay
		Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	20% of the cost	20% of the cost
		Tier 4 (Insulin)	$35 Copay	$105 Copay
		Tier 4 (Non-Preferred Drug)	25% of the cost	25% of the cost
		Tier 5 (Specialty Tier)	25% of the cost	Not Applicable
	Preferred Mail Cost-Sharing	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	Not Applicable	$0 Copay
		Tier 2 (Generic)	Not Applicable	$7 Copay
		Tier 3 (Preferred Insulin)	Not Applicable	$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	20% of the cost
		Tier 4 (Insulin)	Not Applicable	$105 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	25% of the cost
		Tier 5 (Specialty Tier)	25% of the cost	Not Applicable
	Standard Mail Cost-Sharing	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	Not Applicable	$21 Copay
		Tier 2 (Generic)	Not Applicable	$51 Copay
		Tier 3 (Preferred Insulin)	Not Applicable	$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	20% of the cost
		Tier 4 (Insulin)	Not Applicable	$105 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	25% of the cost
		Tier 5 (Specialty Tier)	25% of the cost	Not Applicable
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $2,100, the plan pays the full cost for your covered Part D drugs. You pay nothing.			

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Highmark Blue Cross Blue Shield is a Medicare Advantage HMO, PPO, and/or Part D plan with a Medicare contract. Enrollment in these plans depends on contract renewal.

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All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

This information is not a complete description of benefits. Call 1-866-746-7971 (TTY users may call 711), October 1 – March 31, 8 a.m. to 8 p.m., 7 days a week; April 1 – September 30, 8 a.m. to 8 p.m., Monday – Friday for more information.

TruHearing® is a registered trademark of TruHearing, Inc. TruHearing is an independent company that administers the routine hearing exam and hearing-aid benefit.